There are some specific recommendations that I would like to see this committee make. I'd like to see adequate dosing being the cornerstone. I know that there is a lot of attention or a lot of hopes that if you can pull the accreditation bodies in for monitoring, that this will solve bad care, but I'm not sure that the accreditation that I understand it to be will provide good patient care. There are ways you can have outcome studies measure certain services and still come up with that treatment and good outcomes, and we've seen it from patients that are referred to us from accredited programs now.

You could take, for instance, an FDA detox, where you measure whether the patient--by the rule now, they have to see the doctor once a month. They have to go down on the dose so that they reach a zero milligram dose by the conclusion of the treatment. You can look at whether they provided a urine specimen every month and how well your counselors were doing case management. Those things, you can measure very well.

Our FDA detox is a good idea. Our experience is they're not, and I know that the speakers have come forward today and talk about, well, we agree with the two-day waiting period versus the seven-day waiting period. What we found was the patients are exposed to infectious diseases right through the whole detox.

So if you have someone who's under-medicated at the beginning of their detox and you are withdrawing them slowly over a period of six months, what you're going to find is that the patients--you won't have to worry about the two-day waiting period at the end because your patients will be leaving well before that period where the withdrawal schedule even comes up and I think it's naive of the panel members to think otherwise.

One of the things we found out, what I found out from working with the Illinois methadone chapter, the association, is that many of the problems that they're having in their community relate to under-dosing their patients. They would report to us that they had people that would stay

around the program and sell drugs that would be more harmful than other narcotics, even, like Clonadine and pills that would, you know, affect their behavior in some adverse way. And none of these drugs really take care of the craving for the narcotics that, in the event that they had an adequate dose, would have taken care of.

So they're more exposed to the effects of these other drugs, which could cause emergency room admissions, cost taxpayers many dollars, and this is all because they don't provide adequate doses. I don't believe the accreditation models really talk about adequate doses.

One of the other things that we've found is training physicians about methadone. Even our ASAM physicians that we have talked with peripheral to the field really don't know about methadone treatment. There doesn't seem to be any adequately-trained physicians, and I say peripheral to the field, where they have a good knowledge base of how to practice methadone treatment. Oftentimes, they have problems with putting

patients over a certain dose of methadone which would alleviate the withdrawal symptoms.

So we would believe that training physicians first about patient advocacy would be the start. In many clinics, physician training usually occurs from the counseling, nursing, and administrative staff. When medical training occurs from the clinical staff, the physician stops practicing medicine. This turns into a very difficult problem for the patients. They really feel that they aren't cared for, that they don't have a voice in their treatment.

Subsequent training for administrative and clinical staff about the efficacy of methadone as a pharmacological treatment, clinical staff must be trained by qualified methadone physicians to learn about the efficacy of methadone dosing practices.

In our own State of Illinois, many public clinics have mandated clinical services, or forced mandated clinical services on an inadequately medicated opioid population. Thereby, the patients remain in the clinic vicinity while exposed to

impulsive drug-seeking behavior. The programs are a magnet for drug dealers and others who exploit the patients. Drug markets are created while patients who could have been humanely cared for are now subject to predators and exposed to the public health concern, including infectious diseases such as Hepatitis C and HIV. These patients also compromise themselves to the criminal justice system.

Inadequately trained program staff promote an atmosphere of distrust of the pharmacological benefits of methadone treatment, resulting in poor patient outcomes, which result in illicit drug use and adversely affect patient retention.

I've got a lot of papers here. In the new regulations, there are some things that were just a complete puzzle to me and my colleagues. The recording of medication doses above 100 milligrams and 25, 30 years after the studies of Neiswander and Dull, it escapes me how there could even be a mention to put in a note in the medical chart that a patient has to go above 100 milligrams.

I've heard this commented on by previous speakers and I wanted to comment on it again. It's almost our belief that there should be a note in the medical chart when the patient isn't above 100 milligrams, given the quality of heroin on the street and the kind of population that we're working with now, pain maintenance patients, patients exposed to a purity of heroin that far exceeds what was on the street when the early research occurred.

Mandated detox schedules, they're inhumane, period.

I would say about the detox schedules, they usually occur to patients that are very young. Anybody in the field right now understands that we're getting a very young group into methadone treatment and these patients are much more immature than the patients that we've had for a number of years that are currently stable. When you mandate a detox with them, they don't have the insight of other patients and often when they leave treatment, they have a bad view of it. They're not readily

able to come back right away.

What happens is the clinics are put into a position where we have to play a paperwork tug of war with people like Elsworth Drury, who is a pleasure to deal with, by the way, as well as our State agencies. So this kind of cumbersome procedures just are not necessary.

One final thing that I want to talk about is State monitoring. I know that there is a question about what is going to happen with the accreditation model if it's approved for methadone treatment. Are we going to have three people looking over our shoulder now? It's unclear to us whether the FDA is withdrawing from its monitoring authority.

Most of our paperwork comes from the State, so if you have an accredited--if we have standards that we have to follow now and we still have to have the State to report to, the kind of effort that we will have to put in, and I'm talking about we, every program, is going to be monumental. There has to be some sensitivity to the kind of

sversight that the programs are going to have to adhere to.

That's not my final remark, by the way.

This is something on LAAM. I know that we nave people that are from Roxanne and everything, out regarding LAAM, the prohibition of carry doses nas always been based on fear. As we know, LAAM nas a lower potential of abuse than other narcotic agonists. Patients often experience unpleasant side effects during the induction phase. Given a choice, most patients do not embrace this medication to treat their opioid dependence.

We find LAAM is a good drug to use with those that are being tested, especially the people who are being monitored by the Department of Transportation who will get fired, legally get fired, if they test positive for methadone.

There's no evidence to suggest that the controls of this drug, meaning no carry bottles of LAAM, was ever medically justified. In the past, I suppose DEA was concerned about the overdose potential of the drug. However, physicians could

use a combination of short-acting drugs like Narcan and long-acting narcotic antagonists like notrexin hydrochloride or buprinorphine to counter the longer-acting effects of LAAM in the event of an emergency room admission for overdose.

We support the ability for patients to receive LAAM carry medication. Some patients do not choose LAAM as their medication based on the regulatory restrictions associated with this drug. In the future, other opiate agonists or combination agonist/antagonist drugs may be introduced to the milieu. Clinics will not get a clear picture of the efficacy of the new drug/substitute drug if the restrictions are unevenly imposed in the dispensing of the drug. So we really don't have a clear idea of who would prefer LAAM just based on these restrictions.

Finally, I guess, this kind of relates to 'accreditation, in a way. About 25 years ago, I won the lottery. The lottery was the draft, and the draft was, greetings. As I kind of escaped my parents' household and was living a life in

Florida, I got this letter and I realized that I'd have to go to Chicago or get to school or get married or become gay or something in order to not serve my country, which was my desire and my goal at the time. So I went to some friends of mine who had just got drafted, or I wrote them, and they told me, you'd better join, because if you don't, they're going to get you in the Marine Corps. The only thing I was afraid of worse than the Army was being drafted and put in the Marines.

So I went down to the recruiter's office and I talked to the recruiter and I asked the recruiter, what could I expect from this, and he told me, you can expect adventure, you can expect to meet new cultures, and you'll learn a lot about discipline.

About two years later, as I was laying in the VA hospital after my combat duty in Vietnam, I realized that everything that the recruiter kind of said was true, but it wasn't the adventure I was really looking for. I'm not sure accreditation is the adventure we're looking for.

[Laughter.]

DR. LEPAY: Thank you. Any questions?

[No response.]

DR. LEPAY: Thank you for your entertaining postscript.

Annie Umbricht? Would you also introduce your affiliation?

DR. UMBRICHT: Hi. My name is Annie Umbricht, and a lot of what I'm going to say replicates what Ernest Drucker said or Holly Catania, but maybe I thought that being an internist, it also had its value to be heard from the voice of an internist.

I want first to start questioning the number of heroin addicts in this country. Eight-hundred-thousand is the official approved number. However, I also know that about 2.5 percent of the U.S. population is under lock. I also hear that 80 percent of those have been incarcerated for a drug abuse problem. Well, of course, some have been caught because of marijuana, but I think it's still conservative to estimate that 25 percent of all

incarcerated population has been incarcerated while being a heroin addict. So that would bring the number total to 2,360,000 heroin addicts in this country, and to be incarcerated doesn't mean to be clean.

The one good thing that I heard about accreditation is that it might help methadone come into the mainstream medicine or increase the credibility of methadone maintenance in the more accepted type of medicine.

In my view, doctors have never been inclined to learn about something they cannot do, or even less, about something that has an accreditation process.

[Laughter. 1

DR. UMBRICHT: The best way, in my view, to put methadone treatment into the mainstream of medicine is to deregulate it and teach addiction medicine, including methadone maintenance, as part of medical school curricula and residency program. And in terms of residency program, I include internal medicine, family medicine, primary care,

part of internal medicine is general internal medicine, adolescent medicine, that is part of pediatrics, psychiatry, emergency medicine, and, why not, orthopedic surgeons who are taking care of trauma patients and chronic pain patients. I forgot anesthesiology with chronic pain.

JCAHO accreditation, I think that Ms. Dow left the room, correct? I'm not known for being very diplomatic. Where have you been? You tell us that you have been accrediting close to 86 programs for alcohol and drug abuse treatment, that you have been a patient advocate in the behavioral field. Where have you been? Have you accredited those programs without requiring them to provide methadone maintenance, which is known to be the main and most effective treatment for heroin addiction, and this at the time of the HIV epidemic.

JCAHO is, in my view, a Cadillac for the poor. I'm sorry. I'm from Europe and Cadillac used to be the great car when I was growing up. So I don't think it's affordable, unless there is

something that I don't know and the Federal funding to give this treatment is going to quadruple in the next year. Has anybody heard about that? Otherwise, I think the greatest risk of JCAHO is to shut down programs.

I have lived in this country only for 15 years. When I left very conservative Switzerland, the word methadone--and that was four years after medical school--the world of methadone was not very well known to me. I knew it was some kind of an opiate. That's about all I knew about it. And also, the HIV epidemics, my husband had been in the hospital where the first HIV cases had been described with PCP pneumonia, so I knew about it, but otherwise, it was something from across the ocean.

Well, within five years, by the early 1990s, Switzerland had the highest rate of HIV infection and mostly among drug users. Within a few years, based on U.S. done in this country, health policy changes were drastic. Methadone was made available through doctors' offices. At the

same time, structured methadone programs mushroomed, which means one does not have to threaten the other. And in pharmacies, injecting equipment was made available at production cost, in a word, purchased.

Those changes were made without implementing measurements for collecting outcome, which was one of my criticisms. However, realizing that, in the meantime, there have been papers published and several of them coming last year from Europe, showing a marked decrease in Hepatitis C, and Hepatitis C is very much more catching than HIV. In the Baltimore area, 95 percent of drug users are Hepatitis C positive and they get it within the first two years of injection.

Well, the rate of Hepatitis C in Geneva went from 60 percent to 30 percent among drug users entering methadone treatment, and the same thing happened for HIV, where there was a decrease by half of the number of HIV-infected.

The same has been true for Austria and Germany and now France, although I want also to say

two words about France. In Europe, the experience has been that only a maximum of eight percent, up to 12 percent after a few years of experience, of physicians, of general practitioners have any interest at all in treating drug users. I would suggest that instead of putting huge barriers to those physicians who are volunteering their time and effort to provide care to this under-served population that it's difficult to care for, that we should empower those physicians, educate them, and allow them to practice good medicine.

I would also say, not to restrict the practice of methadone maintenance to certain specialties. I cannot believe that an infectious disease specialist who has learned to prescribe triple-anti-retrovital therapy [ph.] cannot learn to prescribe methadone safely, just as a comment.

In France, methadone became available, or became legally, how should I say--I mean, they allowed the use of methadone for medical maintenance of heroin dependence in March of 1995. Within the year, the number of methadone patients

went from 300 to 3,000. Buprinorphine was made legally available in June of 1995. However, it did not come to pharmacies until February of 1996. The number of total overdoses in France went from 505 in France in 1994, and I'm not sure what the population of France is by now, to 97 in 1998. Those numbers have been published in the French literature in June of this year.

In those 97 patients who were reported as overdose, there were 13 overdoses including buprinorphine, usually as combined with benzodiazepine. So even if buprinorphine might be incriminated, it has saved more than 300 lives--400 lives, and this is just to talk about overdoses.

I want to share two experiences. One is a patient that I took over in my primary care practice that I have once a week. He was a renal transplant patient. You don't want to take care of renal transplant patients. I was very happy that the renal doctor would be continuing the renal transplant care. Chatting with the patient doing my H&P, I asked about pain. That's my custom. As

a good physician, I think that's what I need to do. And I got some reluctant acknowledgement of pain. I had to push him to ask about duration, blah, blah, blah, what you need to do in alleviating pain, and the patient was really reluctant.

What I'm trying to say, he was not drug seeking until he took off his hat and showed me scratching, fresh scratching lesions in his scalp. That patient who had had chronic DBTs and an umbrella placed because of those DBTs that had caused several pulmonary emboli had had chronic lower extremity pains, chronic ulcers, and I hear that those pains are extremely incapacitating. He was basically couch-ridden in front of the TV, not doing anything because of the pain.

I started him on MS contin, and obviously--well, I didn't say the most important thing. This patient had been clean from drug use for 15 years. His renal doctor was very reluctant to start any opiates on him. Of course, given his renal transplant, the nonsteroidals were totally out of the question. So I started him on a low dose of MS

contin, and, of course, as soon as he was exposed to opiates, his tolerance went up again, which is pretty much what I expected. I still went up with the dose until paritis became a problem.

So I bit the bullet and we went for methadone and we increased the dose and he is now on 50 milligram BID. This man has a new life. He's going around in his neighborhood, participating in the community, going and buying new clothes. When he said this, I thought, oh, oh, are you selling your methadone? Is that why you're able?

DR. UMBRICHT: He said, no, I have an interest in going out and buying new clothes. For ten years, he had not done that.

He has been extremely compliant. He called me the other day because his medical assistance, new HMO program, was not going to cover methadone, so that's one other concern of mine, is what is JCAHO going to do about formulary drug therapies? Fortunately, I got on the phone with a very nice medical director and I think I won this

3ame. But that means, for physicians, we have to 30 one patient at a time and spend hours on the phone, and I'm lucky, I can do that. If I had a practice every day of the week, I couldn't do that.

Another story. I was asked to participate in a little demonstration project of office-based methadone maintenance, and so it happened that the hours for that clinic would just follow my medical clinic hours. You cannot imagine how thrilled I was to switch from my medical clinic practice to the methadone maintenance, to find structured, goal-oriented patients, and I was speaking of the methadone patients. They were fantastic compared to my diabetics, my obese.

What I want to say is that we continue to stigmatize those patients. One had been clean for only one year and, basically, they are contributing to the society and they are a pleasure to work with. As far as I know, none have returned to the methadone program because of noncompliance.

Also among those patients--I'm an internist, so I do what I do--I always insist on

smoking cessation, and my success rate among those patients has been higher than among my clinic patients. One quit over two months and he still quit and did not want medication for that.

What I want to say is that those patients need what they have and should have it at the lowest barrier possible, and physicians should be trained for doing this and should be allowed, then, to use their training to their abilities.

DR. LEPAY: Thank you. Any questions?

[No response.1

DR. LEPAY: No questions. Thank you very much.

Mark Beresky?

MR. BERESKY: Hello. My name is Mark Beresky and I am a methadone maintenance patient and a representative of the National Alliance of Methadone Advocates. I'm employed as a trustee and personal representative of a large Colorado family trust. This trust was accumulated by a Colorado judge who was formerly an FBI agent and established by his widow. There's a position of responsibility

and an honor which would have never been offered to me had my life not been resurrected by methadone maintenance therapy.

I've been in treatment in Illinois, Colorado, the State of Washington, and Massachusetts. In light of my experiences with methadone treatment in different States, I believe I offer a unique, first-hand perspective of methadone treatment in the United States.

I've come here today to applaud the spirit of the proposed new regulations, but I believe the proposal has some deficiency in substance.

If we truly aim for better treatment, I believe it is mandatory that we allow methadone patients to provide our unique guidance at every step of clinical oversight and accreditation. No one is more qualified to gauge the efficacy of his treatment than the patient himself. It is his life that we are concerned with and the patient needs to have a say in the process.

For years, patients have been afraid to complain about their clinics or staff. Too often,

a complaint will result in staff sanctioning or punishing the patient, rather than doing an unbiased and fair examination of the complaint. By sanctioning, I mean having their medication withheld or dosage reduced or denying the complainant a supply of take-home medication.

Recently, at a clinic in Colorado Springs, I was abused by a head nurse whom I had observed inappropriately medicating one of her buddies. I complained to the State regulatory agency. They forwarded my letter to this nurse and didn't even bother to respond to me. As a result, this nurse arbitrarily denied me my take-home medication which I had been picking up weekly for years. I was forced to come into the clinic every day to receive my medication. I cannot begin to explain to you the hardships this caused in my life. It is small wonder patients are terrified of complaining.

In addition to seating patients on accreditation and oversight bodies, I propose to establish a patient advocate position at each and every clinic. Clinics would be required to hire a

qualified, experienced, and successful methadone patient to collect patient grievances and monitor patient outcome. Clinics and their staff are not immune to the sophism and stigma regarding heroin addiction and methadone treatment. Far too many are abstinence-oriented and controlling their clientele with punitive rules and by manipulating their medication and dosage levels.

At this same Colorado Springs clinic, the head nurse recently refused to give an increase in dosage to a patient which was ordered for him. When he finally complained enough to have this nurse forced to make the increase, she threw the bottle on the counter and said, "Here, knock yourself out."

I might add here that this clinic prescribes by a policy which is subtherapeutic for a great many of its patients. Heroin use is common for the patients there simply because this nurse has too much control and believes that anything over 80 milligrams is too much.

It's just this type of abuse which must be

reported and investigated. It has been my experience that this type of clinic will create a wall of denial and silence when asked about abuses. They will commonly reflect blame back to the patient by labeling him paranoid or uncontrollable. And since there is no one to investigate fairly, the abuses go on and on and patients learn to keep their mouths shut and become invisible.

In this clinic, I succeeded in spite of the clinic, rather than with their help and support. Patients with years of treatment behind them should be moved immediately to an office-based treatment approach. The clinic system was not structured for those in long-term maintenance, but rather for those coming into treatment with an active addiction. We take up valuable treatment slots and have ceased to need the clinic's services except for its dispensary.

However the new regulations handle office-based treatment, I believe it is necessary to implement office-based treatment quickly, and we must have the mechanism in place to change and

revise regulations as soon as it is deemed necessary. Patients suffer endlessly while committees meet or wait for the holidays to pass.

I believe that a system should be developed whereby new regulations and revised regulations can be put into action every six months. Once again, I must urge you to include patients in these reviews.

One more issue I wish to present, and this is the issue of fee-tox. Fee-tox is the practice by clinics of terminating treatment of patients who lack the wherewithal to pay their sometimes exorbitant fees. The first day in methadone treatment for the heroin addict is the first day he or she can live without having to come up with the cash for his heroin dealer. Frequently, it is the first crime-free day in a long time for this individual.

This comes as a huge relief and a gross burden lifted from his shoulders, but with the lowering of heroin prices, many clinics are almost as costly as the heroin dealer. Patients often are

thrown out of clinics because they cannot pay. It took years for them to get into treatment. Shouldn't we try to keep them there at least until they can have a chance to get back on their feet? We must have relief in place for patients in the first six to 12 months of treatment who have difficulty paying clinic fees. Otherwise, they go back to the street for their medication and to crime to pay for it.

So, to sum up, I would urge the inclusion of methadone patients in clinical oversight and developing new regulations. I believe that all clinics should be required to hire a methadone patient as an advocate for its clientele. Stabilized and successful patients should be moved out of clinic structure and into an OBT setting. And four, we must get Medicaid or some other fund to help patients who cannot afford their treatment. Thank you.

DR. LEPAY: Questions or comments from the panelists?

[No response.1

DR. LEPAY: Thank you very much.

Ira Marion?

MR. MARION: Hi. First, let me introduce myself. My name is Ira Marion. I am the Executive Director and sponsor of the methadone treatment programs that are run at Albert Einstein College of Medicine and Montefiore Medical Center.

I want to assure the panel that despite the governor of Vermont's antipathy about methadone, he didn't learn that at Albert Einstein College of Medicine, where he went to school, because at Einstein and its university hospital, Montefiore, we treat 4,400 patients at 12 methadone clinics. Our programs are comprehensive. They include primary care, mental health care, children and family services, and vocational rehab. This year, we began our medical maintenance project and office-based treatment and have admitted 29 patients thus far.

In general, we support the intent and content of the NPRM. Three of the Einstein clinics and one Montefiore clinic have already engaged in

the CSAT pilot with CARF. I have to confess, we cheated slightly, because before we began, we got two of our staff enrolled as CARF surveyors and they now are helping us to prepare for this eventual accreditation. We've already done our baseline data collection and we look forward to the actual accreditation.

We do have concerns, and I have concerns in general, about the physical plants that methadone treatment clinics are located in. We are convinced that a surveyor or even our own staff would walk into six of our clinics and would not be very happy. Although they tell us clean and safe is the model, some of these clinics are inadequate, as far as I'm concerned. We're pleased that our single-State agency is helping us to find new space for these sites, but they're not going to be ready in time.

One of the reasons I got up and decided to speak is I didn't think that anyone had addressed the multiple stressors that exist in our under-funded and under-staffed treatment system,

particularly those that are located in large cities and particularly those that are dealing with welfare reform on the State and city level.

In New York City, the city is actively engaged in having every patient work for his or her welfare check, including even those that are mandated to go into treatment or require treatment or for whom treatment is required in order for them to receive public assistance. What happens is if they don't show up at their workfare assignment or anything goes awry at their workfare assignment, they're sanctioned, and the sanction includes not only the loss of their welfare benefits, but the loss of the Medicaid that pays for their methadone treatment, subsequently setting up a system where some of these people may be denied care or programs will be denied income for support for that treatment.

That system in and of itself is literally changing the culture in the methadone programs in these cities. Overlaying the accreditation model, there needs to be a major concern and some major

attention paid to these stressors. Some of the other people who spoke talked about some of the other ones.

In addition, referrals of new patients who apply for welfare and for whom treatment is mandated are contingent on how fast the programs move people into workfare assignments, the idea being that if you take six months or three months to do it and another program does it in one week, they will get the referrals because the whole deal is get people into workfare, and not get people the treatment that they need.

On the positive side, because people are being chased off welfare and moved to work, accreditation might open up additional third-party payers by mainstreaming the care. But my own opinion and 29 years of experience tells me this is not enough and the panel and the agencies involved in this model have got to use their good offices to help make third-party payers pay for methadone treatment as part of the health insurance package that insured people carry.

We have recently been successful in getting some of that third-party money, but we've also had other people, other insurance companies, tell us they cover substance abuse treatment but not methadone maintenance. I think this is going to have to be addressed as welfare reform efforts move forward all across this country.

In listening to some of the advocates speak, I'm convinced that accreditation poses a solution to some of the horror stories that they've been telling about inadequate doses or imperious staff or what not. Accreditation requires patient satisfaction, and if the final announcement strengthens that part of the model and gets surveyors to talk to and interact with patients and if patients are surveyors themselves, this would surely help that situation a lot. Clearly, requiring best practice will help some of these imperious people who use their power in methadone programs to inflict harm.

Finally, New York as well as many other States is a State that is fraught with major

process regulations. I am very concerned about the schizophrenia that will ensue as we pursue both the best practice accreditation model alongside these process regulations, and I implore you to address this issue as this thing goes forward so that we'll have a situation where we're only going in one direction. Thank you.

DR. LEPAY: Thank you. Any questions or comments from the panelists?

[No response.]

DR. LEPAY: Thank you very much.

I believe that was the last of our comments today. I want to thank everyone for their participation, certainly those who have commented today. I think we've heard a lot of very valuable information that we will certainly be taking into account as we move forward. For those in the audience who have listened and provided feedback in various other forms, either directly or through comments to those who have otherwise spoken today, we are again very appreciative.

I'd like to thank our panelists today for

their attention and their clear interest in what everyone here has had to say.

From our standpoint, I believe that the notice of proposed rulemaking has a comment period. Comments may be submitted to the docket until the 17th of November. A transcript has also been prepared of today's public hearing. The process by which copies of that transcript can be obtained are detailed in the notice of hearing that we published in the Federal Government.

So, again, on behalf of myself and FDA, I would like to thank everyone here and I will turn this over, as well, to Dr. Clark for any closing comments.

DR. CLARK: On behalf of the Center for Substance Abuse Treatment and Substance Abuse and Mental Health Services Administration, I want to extend our thanks to the people who have taken the time out of their valuable activities to share their concerns and issues. We will be digesting this material after the close of the comment period and, of course, we'll be pointing back to this.

We are poised to participate in the change of the delivery system, and I think that's a key issue. But it isn't just the bureaucracy that you're going to be dealing with, and I think a number of people have raised these issues. We've got to deal with the system of providing care. We've got to deal with patient advocacy. But we also have to deal with public attitude, State regulations, State attitudes, et cetera. If we can deal with these things in a very careful way, we think that we can mark on a new period of substance abuse treatment.

We are turning to you and to the people in the community who could not be here to see how we can best synthesize this new endeavor. It doesn't have to be the final product, but it has to be the best product that we can put together at this juncture in time to make this transition. I think that's the key issue here, that we are in this transition period and we really welcome and value your input.

Does anybody else on the panel want to say

nything?

[No response.]

DR. CLARK: Very good. Thank you again.

[Whereupon, at 3:34 p.m., the proceedings were adjourned.]